DEPARTMENT OF HUMAN SERVICES

FATALITY REVIEW REPORT

FY 2006

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EXECUTIVE SUMMARY

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open case at the time of death or in cases where the individual or their families have received services through DHS within twelve months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2006, one hundred deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were two suicide deaths (2%) and three homicides (3%). The reviews indicate that abuse and/or neglect were contributing factors in six (6%) of the ninety-nine deaths. The Division of Child and Family Services (DCFS) reported that three children died as the direct result of abuse or neglect by their parents/caretakers. The deaths of three individuals receiving services through the Division of Services to People with Disabilities (DSPD) could be linked to the failure of contract providers to provide appropriate client supervision and/or to obtain prompt medical care.

DCFS, DSPD, and the Division of Juvenile Justice Services (DJJS) Fatality Review Committees reviewed the deaths of eighty-nine clients (89%) with three reviews pending. Utah State Developmental Center (USDC) conducted three on-site reviews (3%), and Utah State Hospital (USH) conducted two on-site reviews (2%). There were no reported deaths from the Division of Aging and Adult Services that met Department criteria for review. The Office of the Public Guardian (OPG) reported three deaths (3%) and provided the Fatality Review Coordinator with comprehensive written reports covering services to these clients.

There were fifty-eight (58%) reported deaths of male clients and forty-two (42%) reported deaths of female clients. Reported deaths included sixteen infants (16%) under the age of one year; thirty-one clients (31%) between the ages of one to eighteen years; thirty-three clients (33%) between the ages of nineteen to fifty years; and twenty clients (20%) between the ages of fifty-one to eighty-eight years.

BACKGROUND and METHODOLOGY

In November 1999, the Office of Services Review (OSR) assumed responsibility for reviewing all DHS client fatalities. OSR recognizes the fatality review process as an opportunity to acknowledge good case management, to identify systemic weaknesses, to propose training for Division staff in performance problem areas, to involve Division staff on a local level in the review process, and to make cogent recommendations for systemic improvements.

The fatality review committees consist of a Board member of the Division under review, the Attorney General or designee, a member of management staff from the designated Division and from a region other than that where the fatality occurred, a member of DHS Risk Management, and in the case of a child fatality, the Director of the Office of the Guardian ad Litem or designee, a member of the Child Welfare Legislative Oversight Committee, and any individual whose expertise or knowledge could significantly contribute to the review process. Currently, the Child Fatality Review Committee is greatly strengthened by the membership of a pediatrician who provides valuable insight, both medical and non-medical, into case reviews.

During the past year, the DCFS State Training Coordinator has joined the Child Fatality Review Committee. The Training Coordinator is a direct link between the Fatality Review Committee and Division staff. As the Committee identifies and discusses issues related to problems in practice, the Training Coordinator notes areas in the training curriculum that need development or strengthening and develops training to meet the identified need.

The DSPD Fatality Review Committee utilizes the knowledge and expertise of two regional DSPD Registered Nurses who have on-going personal contact with many of the DSPD clients and who, in many cases, have first-hand knowledge of a decedent's medical history. Their medical knowledge and insight into health and safety issues is of great value to the non-medical committee members.

The Child Fatality Review Coordinator receives notification of client deaths through several channels, e.g., Deceased Client Reports, Certificates of Death, the State Medical Examiner, obituaries, emails, etc. In the case of child fatalities, the Coordinator receives Certificates of Death for every child who dies in the State of Utah. After searching the child welfare database, SAFE, to determine if the family has had services within twelve months of the fatality, the Coordinator requests and reviews the case file, summarizes the family's history of involvement, and makes an analysis pertaining to case practice and agency culpability.

Prior to the monthly DSPD and Child Fatality Review committee meetings, members are furnished with copies of fatality review reports, which they study and note areas for discussion. When deemed appropriate, the Committees invite Division staff and/or contract providers to committee meetings to provide additional information. The fatality review reports, complete with committee concerns and/or recommendations, are then sent to the DHS Executive Director, the Director of the Division, and the Director of the region in which the fatality occurred. The Region has fifteen days in which to formulate a reply and, if necessary, an action plan for carrying out the committee's recommendations. Due to the low number of fatalities in the Division of Juvenile Justice Services, that committee meets on an as-needed basis.

The DHS Fatality Review Coordinator is a member of the State Child Fatality Review Committee, which is coordinated by the Department of Health's Violence and Injury Prevention Program (DOH/VIPP). The Child Fatality Review is a collaborative process that brings people together from multiple disciplines to share and discuss comprehensive information on the circumstances leading to the death of a child, to identify preventable deaths, and to identify interventions to prevent future deaths.

The Early Response Team, reviews deaths in Utah that occur to all children aged 0 – 19 years for all causes of death and aged 0 – 21 years for suicide deaths. Committee members provide social and medical information concerning the decedent's family, which is entered in the Department of Health's child fatality database. This information is used in compiling statistics pertaining to birth defects, congenital anomalies, suicides, abuse, neglect, and accidental deaths. Utah is one of thirteen states participating in a pilot program using a standardized form for gathering information pertaining to child fatalities.

The State Child Fatality Review Committee's Rapid Response Meeting, also coordinated by the Department of Health Violence and Injury Prevention Team, meets with the State Medical Examiners on an as-needed basis to discuss child fatalities for which an autopsy has been performed due to the child's death having happened under violent, suspicious, unattended, or unknown circumstances, or for those children who have committed suicide. This group is made up of representatives from Primary Children's Medical Center's Safe and Healthy Families Team, the Birth Defects Network, the Office of the Medical Examiner, Emergency Medical Technician Services, law enforcement, the Office of the Attorney General, the Office of the Guardian ad Litem, the Children's Justice Division, the State Office of Education, the Department of Human Services, Valley Mental Health, the PCMC Child Advocacy Team, the Shaken Baby Foundation, and the Division of Child and Family Services.

The State Child Fatality Review Committee has been instrumental creating a Suicide Task Force, partnering to complete a six-phase Youth Suicide Study, working toward more comprehensive child restraint and seal belt legislation, and developing news releases, public service announcements, and media events to address the most common injuries among Utah's children. Information gathered is used in the development of public awareness programs for child safety. During FY 2006, data compiled on vehicular "roll-over" deaths lead to the "Spot the Tots" media campaign to bring to public awareness the importance of knowing the location of children before backing up a vehicle.

FINDINGS

The purpose for reviewing a Department of Human Services client death is to assess the Department's culpability in that death, to develop means for preventing future client deaths, and to improve Department services. The review itself evaluates the system's response to protecting vulnerable clients by assessing whether best practices were followed in the case.

During FY 2006, the DHS Fatality Review Committees reviewed the cases of one hundred individuals who had received services through the Department within twelve months of their deaths. The Committees determined that in 97 cases (97%), the provided services did not contribute to the clients' deaths. In three cases (3%) it appeared that inadequate service by contract providers could have contributed to the death of the individuals. Of the thirty-one reported child fatalities three deaths (10%) were attributed to abuse or neglect by a parent or caretaker.

A five-month-old female died after ingesting a lethal amount of methamphetamine while in the care of her mother's paramour. At the time of the infant's death DCFS had an open CPS investigation, but the CPS investigator had not visited with the family. The paramour has been charged with a first-degree felony count of endangerment of a child and abuse or desecration of a human body, and the baby's mother has been charged with a third-degree felony count of abuse or desecration of a human body.

A nine-month-old female drowned after being left unattended in the bathtub in her home. The safety seat in which the infant was placed tipped over, trapping the baby under the water. Although the family had an extensive history of involvement with DCFS, there were no open services at the time of the infant's death.

A fourteen-month-old male died after a near-drowning event that occurred in the bathtub of his home. Prior to the infant's death, an older sibling had been removed from the home due to the parents' mental instability, leaving two younger children in the home. At the time of the infant's death DCFS was providing court ordered in-home services (PSS) to the family. An Order to Show Cause had been filed in Juvenile Court due to the parents' failure to comply with court-ordered services. The child remaining in the home has been removed and has been placed with relatives who now have legal custody of him.

Of the fifty-eight individuals who died while receiving services through DSPD and its contract providers, three deaths (4%) raised concerns regarding appropriateness and/or quality of care being provided by contract providers. The drowning death of one individual emphasized the need for all contract providers to have bathing protocols in place for individuals with seizure and/or behavioral disorders. The choking death of another individual pointed out the need for all of an individual's providers to share the same behavior action plans, thus providing consistent attention in all settings to an individual's health and safety issues. In another case an individual died of dehydration several days after the contract provider's nurse gave treatment advice over the telephone without making an in-person assessment of the individual's condition.

The DHS Fatality Review Committee members identified numerous strengths in service-delivery systems that included noticeable improvement in child welfare's involvement of families in service planning; more aggressive seeking of appropriate kinship placements; and on the part of DSPD Support Coordinators, increased attention to the Health and Safety issues of their clients. Committee members also singled out several areas in which changes or modifications could enhance systemic response to the needs of Department clients that included better assessments of parents' and children's underlying needs, better matching of the level of services to the level of risk of harm, and better monitoring of contract providers. The reviewers also recognized several examples of outstanding case management conducted by Human Services staff.

DIVISION OF CHILD AND FAMILY SERVICES

SYSTEMIC STRENGTHS

In the majority of cases reviewed the quality of work conducted in Child Protective Services investigations and in providing on-going services to families continues to improve over casework conducted prior to the advent of the Practice Model. In most cases reviewed workers saw the child within priority timeframes, conducted appropriate interviews, collaborated with law enforcement when necessary, worked with service providers to meet the needs of their clients, and if removal was necessary, were aggressive in seeking appropriate kinship or foster placements. With the advent of the Practice Model, caseworkers are conducting Child and Family Team Meetings and are working more closely with clients in an attempt to identify client needs and to plan appropriate services.

> Committee members recommended that CPS investigator, Elizabeth Anderson, be commended for conducting an excellent investigation in a case involving an allegation of Physical Abuse. Ms. Anderson saw the child within the appropriate priority timeframe, assessed and photographed marks from the alleged abuse, addressed safety issues in the home with the child's caregivers, set timeframes for the caregivers to correct safety issues, and made a follow-up visit to ensure compliance. She staffed the case with her supervisor and with other professionals as needed and established a trusting relationship with the family.
>
> In a case with an allegation of the Physical Abuse of a child by a stepfather, the CPS investigator, Michelle Lythgoe, was commended for conducting a thorough investigation of the allegation, which included a review of the police report, interviews with the child's mother, father, and the alleged perpetrator, and making arrangements with another state's child welfare system to conduct a courtesy interview of the alleged victim and his sister who were spending the summer with their biological father. Ms. Lythgoe provided casework counseling and offered additional services to the family. The allegation was supported based on information gathered during the investigation indicating that the stepfather's conduct was non-accidental.

SYSTEMIC WEAKNESSES

It should be noted that there were thirty-one DCFS cases reviewed in FY 2006 by the Child Fatality Review Committee, a number that is statistically insignificant when compared with the total number of DCFS cases open for services during that same time period. Because of this fact, the systemic weaknesses and deviations from "best practice" casework identified by the CFR Committee cannot be generalized to the child welfare system as a whole. However, several systemic problems have been noted in multiple cases. In the thirty-one DCFS cases reviewed, the following issues raised the greatest concern among committee members. It is recommended that during FY 2007, DCFS concentrate on improving case practice in these areas.

Assessing Underlying Needs/ Level of Risk - Level of Services

The most prevalent systemic weakness identified by the Child Fatality Review Committee during the past year was the seeming failure of some workers to make accurate and in-dept assessments of a family or individual's underlying needs, and by extension, the failure of the worker to offer appropriate services. In at least twelve of the thirty-one cases reviewed (39%) the Committee noted that workers "missed the mark" in their assessments.

During the course of some child abuse/neglect investigations, family members or third party collateral contacts furnished information to the caseworker indicating that the families were in need of services not directly related to the stated allegation. However, the workers did not address these needs and did not

offer services to the families. Cases were closed with inadequate or no services having been offered. In other cases the allegations of abuse and/or neglect were supported based on evidence gathered during the CPS investigation. However, the cases were closed with no services being offered or provided to the family.

Some workers appear to be making an initial assessment of risk vs. services by following at face value the CPS Practice Guideline of intervening at the "lowest level of intrusion". It does not appear that workers are being trained on the underlying rule of "commensurate with the risk". Some workers did not take into account a family's DCFS history when they were deciding upon the level of intervention necessary. They repeatedly offer voluntary in-home services as though the family was a first-time offender. When a family does not comply with DCFS suggestions for service or if the perpetrator re-offends, the result is continued Division involvement. It appears that some workers believe that initially they cannot pursue a higher level of intervention than voluntary services, failing to understand that the lowest level of intrusion must be "commensurate with the risk".

> DCFS received a referral indicating that a baby had been born with drugs in his system. The baby's mother admitted that she had a drug addiction with her drug of choice being methamphetamines. However, the CPS case was closed with no services in place for the mother and with no corroboration that the mother had complied with the worker's requests to obtain a drug and alcohol assessment and to attend interim group therapy sessions until there was an opening in a residential drug treatment program.
>
> In a case involving a mother with a history of engaging in abusive relationships the caseworkers in two different CPS investigations were diligent in providing the woman with written information concerning domestic violence and in explaining the effects of domestic violence on children. However, the woman's daughter expressed to the caseworkers that she had a need for counseling services. Neither worker documented that he/she provided assistance to the mother in obtaining mental health services for her daughter, and neither worker indicated that he/she followed through to ensure that the mother obtained mental health and domestic violence treatment for herself.
>
> A baby was born with medical problems that necessitated a two-month stay in the Newborn Intensive Care Unit. The mother demonstrated a lack of follow through in visiting the baby in the hospital and in learning how to feed the baby and in learning how to administer medication and oxygen. DCFS opened a Family Home and Risk Assessment case for a family. After the baby was released from the hospital, the caseworker had difficulty locating the family but eventually contacted the mother by telephone. The mother reported that the baby was doing fine and that a doctor was following the baby's progress. Even though the mother gave the worker the name of the baby's pediatrician, the worker did not contact the doctor for a first-hand report of the baby's condition and progress. When the mother declined services through DCF, the worker relied on the mother to make contact with DCFS if she felt there was a need for services. The worker closed the assessment case without having met with the parents, without having seen the home, without having seen the baby and the baby's sleep environment, and without having made a personal assessment of the family's need for services.
>
> A case in which the mental health status of both the mother and the father was seriously underestimated also demonstrates a need for thorough and timely risk assessments. When the oldest of three children was removed from the home due to his mother's irrational behavior, there was a window of opportunity in which the worker could assess the risk factors involved in leaving the two younger children in the home. Because no assessments were made, the children remained in the home until the youngest child died as the result of a near-drowning incident, which was attributed to non-supervision. At that point the older sibling was placed with a relative.

Medical Neglect/Physical Neglect

The Committee emphasized the necessity of workers understanding that the allegations of Medical Neglect and Physical Neglect take on different definitions under different circumstances. A combination of high-risk factors occurring in the same family, e.g., chronic illness, suicide attempts, parental substance abuse, mental health issues, etc., signal the need for a higher level of intervention. In some cases workers follow all the practice guideline steps yet miss the mark as far as identifying the important underlying

factors in the case. Workers need to be trained to respond to CPS referrals with a more thorough assessment of the family's underlying needs.

> A couple that has adopted numerous medically and developmentally disabled children, has been the subject of several CPS investigations. The issues of a dirty home, dirty, smelly children, safety hazards in the home, etc., have warranted repeated Child Protective Services referrals and investigations with little change resulting in the reported conditions. Workers documented that the home was "close to below minimal standards" and closed their CPS investigations with the allegations unsupported and with no services implemented. However, in a home where there are medically fragile children, the "minimal standard" would seem to need to be higher than in a home in which healthy children live.
>
> A young woman with a history of seizure disorder demonstrated clear signs of emotional distress, e.g., attempted suicide, weight loss, and cutting on her body. Seven of the twelve CPS referrals made were unaccepted for investigation. Although the alleged failure of the father to administration the young woman's medications was a central theme in the CPS referrals, there is no documentation that the workers actually determined if the woman was getting the medical and mental health treatment that she required. It appears that this case needed a more global look at the safety of the child beyond the cleanliness of the home and the presence of food. The presence of several high-risk factors elevated the need for workers to make assessments of the girl's safety on more than a surface level.

DIVISION RESPONSES TO RECOMMENDATIONS

Regions have the opportunity to disagree with Committee recommendations and to explain their rationale for practice decisions. If regions agree with the recommendations, they formulate an action plan for implementation of those recommendations.

In response to the Committee's recommendation that the Division train caseworkers on the need to document the reasons for leaving some children in a home where another child(ren) has been removed, Western Region responded with the following action plan:

"Each Community Service Manager will address this issue in their respective workgroups and then in turn, each supervisor will review this practice with each caseworker on their team."

The DCFS Constituent Services Specialist tracks Child Fatality Review recommendations and ensures that regions are responding to the Committee. At the close of Fiscal Year 2006 regional responses to Child Fatality Review Committee concerns and/or recommendations were pending in ten cases. The Child Fatality Review Committee commends DCFS for the thoughtful and thorough responses the Regions and the Administrative Team have provided to the Committee's concerns and recommendations.

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES

COMMUNITY PLACEMENTS

SYSTEMIC STRENGTHS

DSPD Support Coordinators act as advocates for individuals receiving services through the Division and through its contract providers. The DSPD Fatality Review Committee commended staff of several contract providers, RISE Professional Parents, and a DSPD Support Coordinator for their excellence in caring for individuals.

A woman who was receiving Community Living Support services through United Cerebral Palsy (UPC) was hospitalized with pneumonia and with undiagnosed abdominal pain. UPC staff advocated for the woman in requesting that additional testing be conducted to determine its source. When tests revealed that the woman was suffering from an advanced-stage cancer, she was discharged from the hospital and returned to the group home. UPC developed and provided staff with explicit written instructions regarding the documentation of the woman's physical condition, administration of medications, feeding instructions, frequency of physical and visual checks, and emergency procedures. UPC staff provided attentive and compassionate care to the woman and coordinated services with Hospice, thus allowing the woman to remain in her home until her death.

While hospitalized, a client developed a pressure sore on her lower back which, after her release, required weekly monitoring and dressing changes at the Wound Clinic. During the pressure wound treatments, Frontline staff provided one-on-one care for the woman, and they were described as spending "copious amounts of personal time" with her both at the hospital and in working with her on compliance issues surrounding her personal hygiene, diet, and medical programs. The Wound Clinic reported that Frontline staff did an exceptional job of treating the woman's wound, as it healed from a Stage IV wound to the point that she could undergo a skin graft.

TURN staff was commended for the support they gave to a client who had been diagnosed with emphysema but who chose not to stop smoking. Staff assisted the man with grocery shopping and encouraged him to eat healthy foods, to drink less soda, and to stop smoking. Due to staff's encouragement and instruction, the man made improvements in his personal hygiene and in keeping his apartment clean and was able to live independently

The Committee commended the DSPD Support Coordinator and the DCFS permanency worker who shared in the management of the case of a young boy who was diagnosed with numerous medical and developmental disabilities and who had been placed in foster care due to his parents' intellectual limitations that seriously compromised his physical and emotional well-being. The workers skillfully coordinated services between the two agencies. After the child's removal he was placed in a RISE Professional Parent home with foster parents who were trained in dealing with medically fragile infants and who insured that the child received extensive and intensive medical services and therapies from qualified professionals. The foster parents provided a loving home environment in which the child's overall health improved.

SYSTEMIC WEAKNESSES

Monitoring of Contract Providers

In three cases (5 %) the failure of DSPD contract providers to obtain timely and appropriate medical treatment or to provide appropriate supervision appeared to be linked to the death of three individuals.

> DSPD contracted for one-on-one support throughout the day and evening for an individual with a history of frequent, life-threatening seizures of a severity that often required hospitalization. Staff at the residence and at school had been trained on the severity of the seizure disorder and had been provided with and trained on an emergency medical care protocol. Late one evening the individual indicated that she wanted to take a bath, and staff left her alone in the bathtub to allow her "some quite time". While in the bathtub, the individual suffered a seizure and slipped into the bath water. When discovered, the individual was lying face down in the water and was not breathing. Although paramedics were able to restore the individual's breathing, she died two days later after life-support equipment was removed. It was of special concern that an individual with a history of frequent and severe seizures would be left alone in the bathtub. Contractual obligation and best practice would dictate that staff would be positioned in the bathroom or immediately outside an open door in order to respond to any emergency that might arise.
>
> The residential provider for an individual with a history of choking formulated a behavior action plan that addressed teaching the individual safer eating habits, outlined a choking protocol for staff, and provided for close supervision during meals. The day program provider, different from the residential provider, did not have a formalized behavior action plan regarding choking and did not directly supervise the individual while he was eating. While eating lunch one day, the individual choked on a peanut butter sandwich and aspirated parts of the sandwich into his lungs. The individual was hospitalized, placed on life support equipment, but did not regain consciousness, and died later that day. It was of concern that all providers did not have access to the same behavior action. Had the plan been in place at the day program, the provider could have been more vigilant in supervising the individual during meals and might have chosen a more appropriate food than peanut butter for a person who has a propensity to choke.
>
> An individual suffering from a persistent cough was diagnosed with bronchitis. As the individual's cough worsened, she lost the desire to eat or drink and was resistant to residential staffs' attempts to give her nourishment. When the individual refused to see her doctor for additional medical help, group home staff contacted the contract provider's nurse. The RN, who was suffering from a cold, did not go to the group home to see the individual in person but instead gave directions over the telephone on how to treat the individual. Several days later the individual stopped breathing, was resuscitated briefly, and was later pronounced dead at the hospital. The cause of death was determined to be dehydration. It is of concern that the contract provider nurse did not personally visit the individual or that she did not arrange for another nurse to visit the group home to make an in-person assessment of the individual's condition. A medical professional would have recognized the signs of dehydration, and the individual could have received treatment at a point that might have been life saving.

DIVISION RESPONSES TO RECOMMENDATIONS

The DSPD Regional Directors are to be commended for their prompt and serious consideration of committee recommendations, for the action that they initiate to comply with recommendations, and for their formal written responses to the Fatality Review Committee. However, recommendations addressed

to DSPD administration appear to be ignored. There have been no responses to the DSPD Fatality Review Committee from DSPD administration.

The DSPD Fatality Review Committee noted that over the past few years several individuals have drown after suffering seizures in the bathtub. DSPD has imposed sanctions on the contract providers involved until they have instituted protocols addressing bathtub supervision for individuals with seizure disorder. However, each incident occurred under different providers. With regard to the individual cited above who suffered a seizure in the bathtub, the provider immediately addressed the issue of bath supervision and developed a bath protocol for individuals with seizure and/or behavior disorders. However, DSPD administration has not responded to the Committee's recommendation that it address the issue of developing bathing-supervision protocols with all contract providers or to the more encompassing issue of training Support Coordinators in the area of risk assessment and the formulation of client-specific safety protocols.

DSPD administration has not responded to the Committee's recommendation that Support Coordinators throughout the State be instructed to review behavior action plans for all individuals who are served by more than one provider or who are served in more than one setting. It was recommended that the behavior plans pertaining to health and safety issues be standardized for each provider, thus making each provider aware of the individual's health and safety issues that need to be addressed in all settings.

UTAH STATE DEVELOPMENTAL CENTER

The deaths of three individuals were reported by the Utah State Developmental Center. All three individuals were hospitalized at the time of their deaths, and the cause of death for each individual is listed as "respiratory failure". Although the DHS Fatality Review Coordinator received notification of the deaths of these individuals, there was no notification of a formal review for these individuals.

DIVISION OF AGING AND ADULT SERVICES

During FY 2006, there were no reported fatalities from the Division of Aging and Adult Services that met DHS fatality review criteria.

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

UTAH STATE HOSPITAL

During FY 2006, two fatalities of former USH patients were reported. A woman with a history of poly-substance abuse had been hospitalized for fourteen months for treatment of psychosis. She is reported to have responded to treatment and to have completed a successful trial leave from the hospital. Discharge planning was in place through a county mental health system. Four months after her discharged from USH the woman died of an intentional overdose of over-the-counter drugs including aspirin and a cold medication.

An individual diagnosed with schizophrenia was hospitalized at USH for approximately four years. Medication provided some benefit, and the client was reported to be improved at discharge. The individual died of sepsis following a colonic perforation due to a stool impaction.

The Utah State Hospital Clinical Director and the Clinical Risk Manager 6conducted an on-site Risk Management Fatality review for both cases, as the individuals were not patients at the time of their deaths and because their deaths occurred more than three months after the individuals were discharged from USH. USH provided DHS with a report of its review, and there were no recurring systemic weaknesses identified.

DIVISION OF JUVENILE JUSTICE SYSTEMS

The Committee received notification of the fatalities of three Division of Juvenile Justice Services (DJJS) clients. The manner of death of one youth is listed as "undetermined" with the cause of death being drug intoxication. The youth, who was in JJS custody at the time of his death, was on a home placement at the time of his death. The manner of death of the second youth is listed as "homicide" with the cause of death being a gunshot wound of the chest. He was also in JJS custody, residing at home, and participating in the Diversion program. A third youth had received services through DJJS and through the Division of Child and Family Services but was no longer in JJS custody at the time of his death. He died of injuries sustained in a motor vehicle accident.

SYSTEMIC STRENGTHS

In the cases reviewed by the Fatality Review Committee, youth in DJJS custody received intensive services that included individual and group therapies, medication management, life skills training, substance abuse treatment programs, educational services, and tracking. Case managers and trackers were diligent in monitoring the well-being and compliance of their clients.

SYSTEMIC WEAKNESSES

Due to the small number of cases reviewed for DJJS, the Committee did not identify practice concerns or systemic weaknesses.

OFFICE OF THE PUBLIC GUARDIAN

During FY 2006, the Office of the Public Guardian reported the deaths of three clients. The OGP provided the Fatality Review Coordinator with comprehensive summaries of the clients' service histories and with an explanation of the causes of death. It appeared that all decedents received appropriate services and that their deaths were related to age and medical conditions.

DEPARTMENT OF HUMAN SERVICES
FATALITY REPORT

SUMMARY
FY 2006

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Reviews Held	Reviews Waived	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	**100**	**79**	**97**	**0**	**3**	**58**	**42**
DAAS ***(Division of Aging and Adult Services)***	0	0	0	0	0	1	0
DCFS ***(Division of Child and Family Services)***	30	12	30	0	1	16	14
DCFS/DJJS *(Division of Child and Family Services/Division of Juvenile Justice Services)*	1	1	1	0	0	1	0
DJJS ***(Division of Juvenile Justice Services)***	2	2	0	0	2	2	0
DMH ***(Division of Mental Health)*** **USH** ***(Utah State Hospital)***	2	0	2	0	0	0	2
DSPD ***(Division of Services for People with Disabilities)*** **COMMUNITY PLACEMENT**	57	57	57	0	0	33	24
DSPD *(Division of Services for People with Disabilities* **USDC** *(Utah State Developmental Center)*	3	3	3	0	0	2	1
DSPD/DCFS *(Division of Services for People with Disabilities/Division of Child and Family Services)*	1	1	1	0	0	1	0
OPG *(Office of the Public Guardian)*	3	3	3	0	0	2	1

CHARTS

CHART I

SERVICES PROVIDED WITHIN 12 MONTHS OF CLIENT'S DEATH FY 2006

Division of Aging and Adult Services
Adult Protective Services (APS) - 0

TOTAL: 0

Division of Child and Family Services
Adoptive Assistance Maintenance (AAM) - 1
Child Protective Services (CPS) – 24
Court-ordered In-home Services (PSS/PFP) - 3
Foster Care (SCF) - 1
Guardianship Subsidy – 1
Home and Family Risk Assessment (IHS) - 2

TOTAL: 32

* Total includes services for one DCFS/DJJS client.

Division of Juvenile Justice Services
Diversion Program - 1
Tracking - 1

TOTAL: 2

Division of Mental Health – Utah State Hospital
In-patient Hospitalization - 1
Residential - 1

TOTAL: 2

Division of Services for People with Disabilities – Community Placements
Case Management – 4
Community Living Support Services - 25
Day Support Services - 7
Family Support Services (SAM) - 13
Personal Assistance Services – 6
Professional Parent Home - 3

(Most DSPD individuals were open for more than one service. The primary service is listed on this table.)

TOTAL: 58*

* Total includes services for one DSPD/DCFS client.

Division of Services for People with Disabilities – Utah State Developmental Center
Residential - 3

TOTAL: 3

Office of the Public Guardian
Guardianship Services – 3

TOTAL: 3

CHART II

FIVE-YEAR COMPARISON
FY 2002 – FY 2006

	FY 2002	FY 2003	FY2004	FY 2005	FY 2006
DHS Reported Deaths	111	106	95	106	100
DAAS	3	0	1	1	0
DCFS	36	50	35	40	31
DCFS/DMH	1	1	0	0	0
DCFS/DSPD	1	1	2	1	1
DJJS	2	5	1	7	2
DJJS/DCFS	2	0	0	0	1
DMH/USH	6	7	6	2	2
DSPD	43	29	39	43	57
DSPD/USDC	3	5	8	5	3
DSPD/DMH	2	1	0	0	0
OPG	12	7	3	7	3
Cases Open at Time of Death	83	70	66	76	79
Reviews Held	104	96	92	101	97
Abuse & Neglect Deaths	9	6	9	5	6
Accidental Deaths	18	21	10	13	8
Homicides	7	5	3	4	3
Motor Vehicle Related Deaths	7	14	2	8	3
Suicides	10	11	2	9	1

CHART III

AGE AT TIME OF DEATH
FY 2006

AGE IN YEARS	DHS	DAAS	DCFS	DJJS	DMH/ USH	DSPD	DSPD/ USDC	DSPD/ DCFS	OPG
< 1	**15**		16						
1 – 3	**3**		3						
4- 6	**6**		3			3			
7- 10	**5**		1			3		1	
11 - 14	**8**		3	1		4			
15 - 18	**9**		5	2		2			
19 - 30	**15**	0				14	1		
31 – 50	**18**				1	16			1
51- 65	**12**					10	2		
66 – 80	**5**				1	3			1
81 - 90	**3**	0				2			1
91 - 100									
TOTALS	**99**	**0**	**31**	**3**	**2**	**57**	**3**	**1**	**3**

CHART IV

CAUSE OF DEATH
FY 2006

	DHS	DAAS	DCFS	DCFS/ DJJS	DJJS	DMH/ USH	DSPD	DSPD/ DCFS	DSPD/ USDC	OPG
Head/Brain Trauma										
Alzheimer's Disease/Dementia										
Asphyxiation										
Bacterial Infection/Sepsis										
Blunt Force Injuries										
Cancer										
Drug Intoxication										
Gunshot Wound	**3**	**1**	**1**		**1**					
Heart-related Problems										
Multiple Sclerosis	**1**									**1**
Organ Failure										
Other										
Pneumonia										
Premature Birth										
Respiratory/Pulmonary										
Seizure Disorder	**3**		**1**				**2**			
SIDS	**1**		**1**							
SIDS vs. Positional Asphyxia	**5**		**5**							
Undetermined/Pending										
TOTALS	**101**									

CHART IV

SUICIDE DEATHS
FY2006

MANNER OF SUICIDE	GENDER	AGE	USH
Poly-drug Toxicity from OTC Medications	FEMALE	40	1
TOTALS	1		1

CHART V

HOMICIDE DEATHS
FY2006

MANNER OF HOMICIDE	GENDER	AGE	DCFS	DJJS
Methamphetamine Poisoning	FEMALE	5 months	1	
Gunshot Wound	FEMALE MALE	16 years 13 years	1	1
TOTALS	MALE – 1 FEMALE - 2		2	1

CHART VI

ACCIDENTAL DEATHS
FY2006

CAUSE OF DEATH	GENDER	AGE	DCFS	DCFS/DJJS	DSPD
Asphyxiation	MALE	7 months	1		
Aspiration of Food	MALE	62			1
Drowning	MALE FEMALE	15 months 9 months, 19	2		1
Motor Vehicle Accident	MALE	4, 4 16	2	1	
TOTALS	MALE - 6 FEMALE - 2		5	1	2

CHART VII

ABUSE/NEGLECT DEATHS
FY 2006

CAUSE OF DEATH	DHS	DCFS	DSPD
Choking	1		1
Dehydration	1		1
Drowning	3	2	1
Methamphetamine Poisoning	1	1	
TOTALS	6	3	3

CHART VIII

MEDICAL EXAMINER'S DETERMINATION
MANNER OF DEATH
FY 2006

MANNER OF DEATH	DHS	DAAS	DCFS	DCFS/ DJJS	DJJS	DMH/ USH	DSPD	DSPD/ DCFS	DSPD/ USDC	OPG
Accident	8		5	1			2			
Homicide	3		2		1					
Natural Causes	79		18			1	53		3	3
Pending	0									
Suicide	1					1				
Undetermined	9		6		1		2			
TOTALS	100	2	31	1	2	2	57	1	3	3